The GeriJournal

Volume 12, Number 5
May 2017
A publication of GeriatRx Pharmacy

New Opioid Guidelines

Too many opioid related adverse events and deaths… Too many patients/residents being prescribed high dose opioids. The result - regulatory bodies are now pushing prescribers to use these drugs more judiciously.

The latest salvo in this war on opioids is the release of the *Guideline for Opioid Therapy and Chronic Noncancer Pain*. It was created by a panel of clinicians, guideline specialists and patients and was released this month in *CMAJ*. Ten key recommendations direct prescribers to reduce doses of opiates or seek alternatives to them. Opiates used for cancer are excluded from this article.

The first recommendation advises the prescriber to maximize nonopioid treatment. Medications such as Tylenol, NSAIDs (e.g. Celebrex® and naproxen) which are generally discouraged in the elderly, SNRI antidepressants (e.g. Cymbalta®), anticonvulsants (e.g. Lyrica®, Neurontin®), topical anaesthetics, and nerve blocking agents would be options. Graduated exercise and behavioural therapy should also be considered.

If this fails, opiates may be considered for some residents. Those with drug dependence histories or unstable psychiatric disorders should not receive these drugs. The risk of harm or the reemergence of abuse issues is high. Starting doses should be less than 50mg morphine equivalent per day (i.e. 10mg hydromorphone) and maintenance doses should not exceed 90mg morphine (16mg hydromorphone). There can be some exceptions to these dose caps, but a second opinion should be sought if higher doses are to be considered.

Individuals taking 90mg of morphine equivalent or more should have their doses tapered to the lowest effective dose. This action will often be successful, but if pain increases or there is functional decline one month after the reduction, it should be abandoned. For residents who have inadequate pain control, regardless of dose, switching to another opiate is recommended. A *Switching Opioids* document has been attached to the digital version of this newsletter to assist in the process. Combining a taper with the switch is an option for safety and to initiate reduction.

MAiD Update

It's been almost a year since our involvement in the first LTC MAiD case in Ontario. MAiD was a tremendous advance for individuals with progressive, devastating conditions, who wanted to take control of their remaining days and end their suffering.

The original MAiD legislation was a bit imprecise, however, and had a number of gaps as a result. Some of those have been closed by new legislation, *The Medical Assistance in Dying Statute Law Amendment Act*, passed by the province on May 9th.

Physicians, NPs and other members of the health care team involved in the process are now protected from liability, unless they are negligent in some way. Some insurance policies deny coverage if the cause of death is determined to be "suicide". MAiD patients will be exempt from such provisions. There were also concerns that health care providers and facilities could be forced to reveal information regarding MAiD cases. The new legislation protects them from disclosure.

The province has established a referral service to assist MDs & NPs in finding practitioners with experience in this area. *A MAiD Information for Patients* document is also available. MAiD is a process with emotional and ethical flashpoints. Increased clarity and support eases uncertainty at this difficult time.

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